DOCUMENT RESUME

ED 460 515 EC 306 891

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TITLE Exploring the Relationship of Intensive Treatment Environments to Community-Based Care.
PUB DATE 1996-02-00
NOTE 6p.; In: A System of Care for Children's Mental Health: Expanding the Research Base. Proceedings of the Annual Research Conference (9th, Tampa, FL, February 26-28, 1996); see EC 306 844. Tables and figure are not available from ERIC.
AVAILABLE FROM For full text: http://rtckids.fmhi.usf.edu/Proceed9th/9thprocindex.htm.
PUB TYPE Reports - Research (143) -- Speeches/Meeting Papers (150)
EDRS PRICE MF01/PC01 Plus Postage.
DESCRIPTORS Age Differences; Children; *Community Programs; Foster Care; Individual Characteristics; *Mental Disorders; *Mental Health Programs; *Residential Programs; *Severity (of Disability); *Student Placement; Symptoms (Individual Disorders)
IDENTIFIERS Ohio

ABSTRACT

This study examined specific behavioral characteristics of children in four different treatment environments by an Ohio child mental health agency, in order to shed light on placement decisions in relation to levels of care and severity of symptoms. Data were collected from approximately 300 total program admissions above age 5, each quarter, for an 18-month period of time. The children were in four different treatment environments, including an intensive pre-adolescent residential treatment program (n=90), a pre-adolescent day treatment program (n=51), an urban pre-adolescent, school-based mental health program for children with severe behavior disorders (n=24), and a treatment foster care program (n=166). Results indicate that children in different levels of intensive care can be distinguished by the severity of their behavioral characteristics. Those with more severe symptoms were in residential care. It also appears that some of the "youngest and the deepest" of these children may be at the highest risk for having treatment needs neglected or delayed until they have experienced numerous treatment failures or dangerous levels of symptom severity. (CR)

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The 9th Annual Research Conference Proceedings, A System of Care for Children's Mental Health: Expanding the Research Base (February 26 - 28, 1996).

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Exploring the Relationship of Intensive Treatment Environments to Community-Based Care

Authors

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Introduction

The impetus toward providing community based care is a powerful driving force in the managed care revolution impacting changes in the child welfare and mental health systems. Unfortunately, there are still children who require intensive treatment environments in order for the treatment to be effective in assessing, stabilizing, and treating highly disruptive and potentially dangerous behaviors. Some researchers suggest that intensive treatment environments such as inpatient or residential are not necessary if home-based intervention is available (Stroul & Friedman, 1986; Tuma, 1989 Weithorn, 1988), and that these environments may be detrimental to the future functioning of youth (Henggeler, 1989). Others propose that inpatient treatments, particularly those with specialized treatment interventions, may be a beneficial option (Pfeiffer & Strzelecki, 1990). While intensive treatment such as residential care may be a viable treatment option for some high-risk youth (United States General Accounting Office, 1994), not enough is known about these programs to provide a clear picture of which kinds of treatment approaches work best with different subpopulations of youth with severe emotional disabilities (SED). Current understanding is limited and primarily anecdotal regarding how best to combine intensive treatment environments with home-based care alternatives to serve the most at-risk youth over time. Programs with a diverse continuum of service-intensive care that serve youth through a variety of different models and environments may be in a strong position to shed light on this question.

It is evident that intensive treatment environments can no longer be conceptualized as stand alone services; rather, they must be conceptualized and operated as part of a highly integrated continuum of care to serve high-risk youth and their families over time. This continuum of care may provide the necessary ingredients to maximize treatment

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effect, particularly through the interaction between wraparound services and specialized programmatic milieus. Anecdotal clinical experience and data suggest that there are still important practice issues and dynamics that need to be studied and resolved before intensive treatment milieus can be completely removed from the child mental health continuum.

Method

Specific behavioral characteristics of children in four different treatment environments were examined in order to shed light on placement decisions in relation to levels of care and severity of symptoms. Data were collected from approximately 300 total program admissions above age 5, each quarter, for an 18 month period of time. Each child's scores on the Devereux Scales of Mental Disorders (DSMD: Naglieri, LeBuffe, & Preiffer, 1994) were averaged by scale, composite, and total score reflecting their behavior throughout the specified level of placement. The children were in four different treatment environments at Beech Brook, a child mental health agency. The four programs included: an intensive pre-adolescent age residential treatment program; a pre-adolescent age day treatment program; an urban (Cleveland Public Schools) pre-adolescent age school based mental health program for children with severe behavioral handicaps (SBH); and a treatment foster care program. The sample included 90 children in residential treatment, 51 children in a day treatment/partial hospitalization program, 24 children in an urban school-based mental health treatment program, and a total of 166 pre-adolescent and adolescent youngsters in a treatment foster care program. Of this sample of 331 children, 61% were male, 39% female, and 74% were African-American (see Table 1). The primary focus of this investigation was to determine if the type and severity of child behavioral characteristics as measured by a standardized behavioral rating instrument accurately discriminated children in different intensive treatment environments. A secondary focus of this investigation was to explore whether these findings could help identify clinical and practice issues inherent in treating the most "deep-end" youth, many of whom have had access to an array of community wraparound service options.

The DSMD is a 110-item (or 111-item for the adolescent version) behavior rating scale designed to evaluate behaviors related to psychopathology in children and adolescents. There are two separate instruments, with comparable items and subscales&endash;one for children ages 5 - 12 and the other for children ages 13 - 18. The instrument has three composite scores (externalizing, internalizing, and critical pathology) and each is made up of two subscales (conduct and attention [or delinquency for adolescents], depression and anxiety, acute problems and autism). An overall total test T-score is also included. The DSMD total and composite scales have excellent internal reliability (Cronbach's alpha of .97 for Total Scale score)

reliability (Cronbach's alpha of .97 for Total Scale score) and test-retest reliability. Also, there is good interrater reliability with a clinical population (Cronbach's alpha of .52 for Total Scale score). The DSMD is well suited for use in evaluating mental health treatment outcome reflecting the full range of psychopathology, including the more severely disturbed behaviors that are often missing from other rating scales. A total test T-score of 60 has been empirically determined to be the best cut-score for differentiating clinical from non-clinical samples.

Results

Preliminary analyses focused on examining comparisons among youth between four different levels of care. Univariate Analyses of Variance (ANOVAs) tests were performed for the six scale, three composite, and total scale DSMD scores. If the ANOVA was found to be significant ($p < .05$), post-hoc Bonferroni tests were performed to identify where the differences between levels of care resided.

The DSMD mean T-scores for children in residential care were consistently greater than for subjects in other levels of care (see Figure 1) and reliably discriminated children in residential care versus treatment foster care on four subscales (acute, anxiety, depression, and conduct), two composite scales (internalizing and critical pathology), and the total scale T-score (see Table 2). The sequencing of the discrimination of children followed the expected direction with children in the most intensive treatment environments having higher scores (indicative of greater dysfunction) and the children in the less intensive treatment environments having lower scores. The DSMD further identified specific problem domains (e.g., depression) related to the most high-risk youth placed in residential treatment. On the average, these youngsters (both male and female) tended to be significantly more depressed than their counterparts in day treatment and foster care. Depression, however, is not the reason that pre-adolescent children are referred to the most intensive treatment environments. It is typically for more acute behaviors and the failure of intensive community-based models to safely manage these behaviors.

Perhaps the most concerning findings were that the youngest children in residential care (i.e., 9 years of age or less) were, overall, the most clinically disturbed across DSMD measures, and as a group had experienced the highest rate of previous placement moves. Independent t-tests yielded statistically significant differences on all DSMD scales (except conduct and anxiety) between the younger residential children (age 9 or less) versus the older residential children (ages 10 - 13; see Table 3). This subgroup (i.e., ages 5 - 9) contains some of the "youngest and the deepest" children in Ohio's child welfare and mental health system for whom previous community treatment has been a series of disrupted placement failures. As a whole, this group appears to be poorly understood, highly under

this group appears to be poorly understood, highly under serviced, and systematically targeted for less intensive treatment options.

Discussion and Implications

The implications of this exploratory study are both practical and theoretical. Practical implications from this study suggest that children in different levels of intensive care (i.e., residential and treatment foster care) can be distinguished by the severity of their behavioral characteristics. It would also appear that some of the "youngest and the deepest" of these children may be at the highest risk for having treatment needs neglected or delayed until they have experienced numerous treatment failures or dangerous levels of symptom severity. While the purpose of this investigation was to identify characteristics of the role that intensive treatment environments may play in continuums of community-based care, controlled studies are needed to determine the relative efficacy of these programs compared to alternative treatment models. Caution needs to be exercised, however, in randomly assigning children with the most severe disturbances due to four issues: safety concerns, the high number of previous treatment failures, the consequences of continued placement failures, and the impact of the subjects' deteriorating clinical course.

Theoretical implications point to the utility of blending wraparound and intensive programmatic models of service to reduce disruptions, stabilize and support placements, and effectively treat youth with chronic, severe impairments. The differential management and treatment of these children requires a broad range of specialized intervention options addressing varying levels of impairment and need that are not quickly or easily remedied. The tendency to separate wraparound models of intervention from programmatic models with highly individualized and specialized services dichotomizes complex treatment realities and distorts the development of best clinical practice protocols. The next generation of treatment paradigms for youth with severe emotional disabilities will blend the flexibility of wraparound services with the episodic intensity of specialized clinical paths and programs.

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Liberton, C., Kutash, K., & Friedman, R. M. (Eds.), (1997). The 9th Annual Research Conference Proceedings, A System of Care for Children's Mental Health: Expanding the Research Base (February 26 - 28, 1996). Tampa, FL: University of South Florida, Louis de la Parte Florida Mental Health Institute, Research & Training Center for Children's Mental Health.